STATE OF NEW HAMPSHIRE
Department of Health and Humans Services — Form **2635** (i)
Division for Children, Youth and Families — June 2005

Instructions for Employment Related Child Care Service Invoice

PURPOSE:
All employment related contract child care providers enrolled through the Department of Health and Human Services must complete a billing invoice to receive payment for providing child care.

INSTRUCTIONS:
Form 2635 is a one-page invoice completed by the employment related contract child care provider. The completed invoice is forwarded to the Bureau of Data Management. The Bureau of Data Management will return forms that have missing or incomplete information.

This invoice must be filled in completely by the individual who will be receiving payment from the Department of Health and Human Services. Complete a separate invoice for each child.

An invoice should be submitted bi-monthly. For payment to be made, the invoice must be submitted no later than 90 days after the delivery of the service. Incomplete or illegible invoices will be returned, and payment may be delayed.

FORM COMPLETION:
Enter the full name and address of the child care provider.

Enter the child's full first and last name and child's ID#.

Enter the provider number.

Enter the contract number.

Enter the dates for the effective billing period.

Enter total hours.

Enter the hours per day for all of the days indicated below **only** if child was in attendance the same amount of hours for every day of the billing period.

Enter date and number of hours for each day care was provided.

Enter the anticipated payment amount.

Sign and date the invoice and mail to the Bureau of Data Management at PO Box 2000, Concord, NH 03302-2000.

PD 05-09

STATE OF NEW HAMPSHIRE
Department of Health and Human Services
Division for Children, Youth and Families

Form 2635
June 2005

EMPLOYMENT RELATED CHILD CARE SERVICE INVOICE

PROVIDER INSTRUCTIONS: Fill in completely and mail one copy to DHHS, Data Management, PO Box 2000, Concord, NH 03302-2000.
Keep one copy for your records

Child's Name and Number:

Child Care Agency Name and Address:

Provider Number: OES Contract: Billing Period: Total Hours

____/____/_____ through ____/____/____ _____

Child was in attendance _____ hours per day for all of the days indicated below.

Only fill in above statement if child was in attendance the same number of hours everyday listed. Otherwise leave the above statement blank and fill in below.

Date: ____/_____/_____ ____/_____/_____ ____/_____/_____ ____/_____/_____ ____/_____/_____

Hours: _____ _____ _____ _____ _____

Date: ____/_____/_____ ____/_____/_____ ____/_____/_____ ____/_____/_____ ____/_____/_____

Hours: _____ _____ _____ _____ _____

Date: ____/_____/_____ ____/_____/_____ ____/_____/_____ ____/_____/_____ ____/_____/_____

Hours: _____ _____ _____ _____ _____

Do not use fractions or decimals for hours, round up.

Anticipated payment:_____, payment cannot be zero.

PD 05-09

_____
Provider's Signature